



# Central Florida HIV Planning Council Regular Membership Application

## About the Planning Council

The Central Florida HIV Planning Council is an integrated planning and advisory body to plan the organization and delivery of services provided under Part A and Part B of the Ryan White Treatment Extension Act of 2009.

### Our Mission:

To improve the quality of life for individuals with HIV by responding to their existing and emerging needs and to provide educational and behavioral strategies to targeted populations, to reduce and prevent the spread of HIV.

### Our Vision:

To ensure a quality continuum of care for all individuals and families infected with, affected by and at risk for HIV disease.

## HIV Planning Council Committees

**Service Systems Planning & Quality:** Responsible for overseeing and making improvements to the system of care from prevention to viral suppression, updating Standards of Care, assessing the efficiency of the Administrative Mechanism, monitoring of performance for clinical quality management activities, and coordinating with federal recipients.

This committee is also responsible for the coordination of integrated planning, the annual Needs Assessment, special studies and town halls, reviewing data and management of data presentation, oversight of the PSRA process, monitoring of expenditures, and approval of reallocations across service categories.

**Membership & Engagement:** Responsible for recruitment and retention of members, ensuring parity, inclusion and representation, overseeing an open nominations process and providing member orientation and training. The committee will make recommendations for committee assignments.

This committee is also responsible for developing marketing and recruitment strategies, maintaining social media and website, providing public information and education, and coordinating community events and activities.

## The Application Process

Complete this Application (be sure to sign the Statement of Member Commitment on page 2) and the Central Florida HIV Planning Council Information Sheet. Return to:

Planning Council Support  
1940 Cannery Way,  
Orlando, FL 32804  
Email: [CFHPC@hfw.org](mailto:CFHPC@hfw.org)  
Fax: (407) 835-0144

- Once received, your application will be reviewed to ensure it is complete. We will send an e-mail to confirm that we received the application.
- You will need to attend a Planning Council meeting and either a committee meeting or the Ryan White Community Meeting.
- After attending the two meetings, as mentioned above, an interview will be scheduled.
- Your application will then be added to the pool of applicants.
- At each monthly Membership Committee meeting, the membership profile of the Planning Council is reviewed. If new members are needed, the committee will review all of the current applications.
- If your application is chosen, you will be contacted to confirm you wish to participate. If you agree, you will be recommended to the Orange County Chief Elected Official (CEO) for appointment to the Planning Council. Generally, it takes about a month for the process to be completed after the interview. You will also be encouraged to begin taking part in Planning Council activities. Once appointed you will be required to attend orientation.
- We will keep you updated on the status of your application.

Contact the Central Florida HIV Planning Council Support

Email: [CFHPC@hfw.org](mailto:CFHPC@hfw.org)  
Phone: (407) 835-0906

Visit our website: [centralfloridahivpc.com](http://centralfloridahivpc.com)



**Gender:**

- Female
- Male
- Transgender (M to F)
- Transgender (F to M)
- Other \_\_\_\_\_

**I identify as (Check all that apply)**

- Gay/Lesbian
- Bisexual
- Heterosexual
- MSM (Men who have sex with men)
- Person Who Injects Drugs (PWID)
- Other: \_\_\_\_\_

**Current Age:**

- 16 to 19 years
- 20 to 29 years
- 30 to 39 years
- 40 to 49 years
- 50 to 59 years
- 60+ years

**Race/Ethnicity:**

- White, not Hispanic or Latinx
- Black, not Hispanic or Latinx
- Asian/Pacific Islander
- Hispanic or Latinx
- American Indian/Alaska Native
- Multi-race (more than one)
- Other: \_\_\_\_\_

**Are you currently or have you ever been a volunteer for any organization(s)**

- HIV/AIDS Organization     Board Member
- Other Organization         Board Member

**List Organizations and hours per week you volunteer:**

\_\_\_\_\_

\_\_\_\_\_

**Have you ever been convicted of a sex crime (examples including Lewd or Lascivious acts, Sexual Battery and Rape, Unlawful Sex with a minor)?**

- Yes     No

**Or a 1<sup>st</sup> degree felony involving violence?**

- Yes     No

**Describe why you wish to become a member of the Health Council:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What skills, abilities and/or experience do you have that can be helpful to the Council?**

- Life experience
- Planning experience
- Rules/Policy Development
- Education/Training Experience
- Budgeting/Financial Planning Experience
- Other - Describe:

\_\_\_\_\_

\_\_\_\_\_

**Please indicate the committee you would like to join:**

- Service Systems Planning & Quality
- Membership & Engagement

**Can we assist you with any special accommodation (such as transportation assistance, wheelchair accessibility, or translation services) to help you participate fully on the Council?**

- No     Yes, I need assistance with:

\_\_\_\_\_

**Do you have any dietary restrictions/needs for meals served at meetings?**

\_\_\_\_\_

**What languages do you speak?**

- English                       Spanish
- Other: \_\_\_\_\_

**Other Comments you would like to share:**

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**The federally mandated categories of Planning Council participation that I am qualified to represent are:** *(please check ALL that apply)*

- Healthcare Providers, including FQHC
- Community Based Organizations serving affected populations/AIDS Service Organizations
- Social Service Providers, including housing and homeless services providers
- Mental Health Providers
- Substance Abuse Providers Local Public Health Agencies

- Hospital Planning Agencies or Health Care Planning Agencies
- Affected Communities including PLWH and historically underserved groups of subpopulations
- Local Public Health Agencies
- Non-Elected Community Leaders
- State Medicaid Agency
- State Agency Administering the Part B Program
- Part D, or if none are operating in the area, representatives of area organizations with a history of serving children, youth and families living with HIV
- HIV/AIDS Treatment Modernization Act Grantees under Part C
- Other Federal HIV Programs (includes HIV Prevention programs)
- Representatives of/or formerly Incarcerated PLWH (release date must be within the past three year

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## CONFLICT OF INTEREST DISCLOSURE FORM

A conflict of interest in an actual or perceived interest in an action that will result or has the appearance of resulting in personal, organizational, or professional gain (i.e., members who serve as director, trustee, board member, salaried employee, subcontractor, or immediate family member\*), or otherwise materially benefit from association with any agency receiving or seeking Ryan White Part A, Part B, Part C, Part D, and/or Part F funding is deemed to have an "interest" in said agency or agencies. Conflict of Interest does not refer to PLWH whose sole relationship to a Ryan White Part A, Part B, Part C, Part D, and/or Part F funded provider is as a client or serving as an uncompensated volunteer.

**I am or have been affiliated within the last six (6) months with the following organization:**

► Organization: \_\_\_\_\_  
 Position: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 ► Organization: \_\_\_\_\_  
 Position: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

**A member of my immediate family is or has been affiliated within the last six (6) months with the following organization:**

► Name of Family Member: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 ► Organization: \_\_\_\_\_  
 Position: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 ► Organization: \_\_\_\_\_  
 Position: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

I do not have an **ACTUAL** or **PERCEIVED** Conflict of Interest in any of the following Service Categories

I have an **ACTUAL** or **PERCEIVED** Conflict of Interest in the following Service Categories:

Actual	Perceived	Core Medical Services
		Outpatient Ambulatory Health Services (OAHS)
		AIDS Pharmaceutical Assistance
		Oral Health Services
		Early Intervention Services (EIS)
		Health Insurance Premium Assistance
		Medical Case Management
		Mental Health Services
		Medical Nutrition Services

Actual	Perceived	Support Services
		Substance Abuse Services
		Non-Medical Case Management
		Food Bank/Home Delivered Meals
		Housing Services
		Psychosocial Support (Peers)
		Medical Transportation
		Emergency Financial Assistance
		Referral for Health Care and Support Services

The Conflict of Interest Form must be completed annually. Changes must be made within 5 days, when necessary.

\*includes father, mother, son, daughter, husband, wife, brother, sister, mother-in-law, father-in-law, son-in-law, or daughter-in-law, as defined by Orange County Government

## Planning Council Information Sheet

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTE:** The HIV transmission categories on this form are those used by the Centers for Disease Control and Prevention (CDC) for HIV and AIDS reporting and monitoring. The information you provide on this form will be compared in aggregate to the epidemiology of the Orlando Service Area (OSA) to determine the reflectiveness of the Planning Council to that of the disease in the OSA. Please select the category that closely identifies your method of infection.

The information disclosed in this attachment will be held in the strictest of confidence as required by Federal and State regulations; only Planning Council Support Staff shall have access. The Membership Committee will be provided this information in aggregate format to monitor the reflectiveness of the Council as a whole as well as the reflectiveness of the un-aligned/unconflicted Ryan White HIV/AIDS Program (RWHAP) clients.

### My HIV status is

- Positive
- Negative
- \_\_\_\_\_ If yes, age at Diagnosis

- I **DO** self-identify\* as a Person with HIV (PWH)
- I **DO NOT** self-identify as a Person with HIV (PWH)

The Planning Council is required to track the mode of HIV transmission for Planning Council Members who are positive. Please check the mode of transmission through which you contracted the disease.

- Men who have sex with men (MSM)
- Person Who Injects Drugs (PWID)
- MSM/PWID
- Heterosexual
- Hemophilia
- Blood transfusion
- Perinatal
- Unknown/Not Reported
- Do not wish to disclose

Applicants who wish to be counted as a client eligible to receive transportation assistance must provide Planning Council Support with documentation of their HIV status (ie. a physician letter, lab results, etc.). Applicants should bring this documentation to their scheduled interview.

\* Self-identify refers to publicly disclosing your status

*Applicants who wish to receive transportation to meetings and/or to be counted as living with HIV are asked to bring documentation of their HIV status to their scheduled interview (i.e. a physician letter, lab results, etc.).*

## **CFHPC Rules of Conduct**

Per CFHPC policies and procedures the Rules of Conduct are the minimum standards for all Planning Council Members and Associate Members are expected to follow when completing Planning Council activities and to provide guidance when working with other stakeholders, the general public and each other.

**Please review the Rules of Conduct and sign on the next page.**

1. The Planning Council operates under the current approved Bylaws and uses Robert's Rules of Order to conduct meetings.
2. Members and Associate Members shall treat everyone with respect at all times.
3. Members and Associate Members shall declare their Conflict of Interest at the beginning of each meeting.
4. The Chair shall establish procedures for discussion.
5. Members and Associate Members shall accept and abide by the agreed-upon process for decision-making and shall accept and abide by the decisions made unless the decision has been rescinded or reversed by procedures utilizing Robert's Rules of Order.
6. Members and Associate Members shall behave in a manner that reflects their responsibility to represent the Planning Council during business meetings and when representing the Council in public.
7. Members and Associate Members shall accept and follow the Council's policies and procedures.
8. Members and Associate Members shall take positive responsibility for helping to prevent and resolve conflicts within the group.
9. Members and Associate Members shall refrain from conduct that is deemed detrimental to the mission of the Council and from jeopardizing the safety of fellow members and Associate Members.
10. Members and Associate Members shall accept shared responsibility for determining the highest priority needs for services by using data and shall use the agreed upon process for determining priorities and allocating resources.
11. Members and Associate Members who feel they cannot support and adhere to the mission of the Planning Council should reconsider their membership on the Council.
12. Members and Associate Members shall take responsibility not only for following these Rules of Conduct, but also for speaking out to assure that all Planning Council members and Associate Members follow them.
13. Members and Associate Members shall ensure that each matter is dealt with in a fair,

equitable, impartial and just manner based on what is in the best interest of the Persons with HIV (PWH) community and other vulnerable populations.

14. Members and Associate Members shall not speak, write or act for the Planning Council without proper authorization from the Executive Committee or Planning Council body.
15. Members and Associate Members shall prepare for, attend and participate in the meetings of the Planning Council and Committees to which appointment has been accepted.
16. Members and Associate Members shall comply with all local, state, and federal laws as they pertain to criminal activities. Members and Associate Members shall refrain from engaging in individual or group conduct that is violent, abusive, indecent, unreasonably loud, or similar disorderly conduct that infringes upon the privacy, rights, or privileges of others, or disturbs the peace or the orderly process of meetings.
17. Members and Associate Members shall value and respect the diversity of the Council.
18. Members and Associate Members shall carry out their duties and responsibilities with due regard to the need to promote equality of opportunity for all people, regardless of their gender, race, disability, sexual orientation, gender identification, age or religion, and show respect and consideration for others.

**Planning Council members and Associate Members must never:**

1. Take improper advantage of their position.
2. Make improper use of information they have obtained.
3. Disclose confidential information.
4. Behave in a manner that will reflect poorly on the Planning Council.

Statement of Zero Tolerance

It is the intent of the Principal's Office of the Central Florida HIV Planning Council to provide a safe environment, and to prevent abusive conduct in any form. The Principal's Office has zero tolerance for direct, conditional, or veiled acts of violence or threats of harm. Members or associate members found in violation of the Principal's Office policies will be subject to immediate discharge from the premise of the Principal's Office.

**By signing I acknowledge that I have read and agree to the CFHPC Rules of Conduct.**

\_\_\_\_\_

**Print Name**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Signature**



## Release/Consent to Publish

### Marketing and Communications Department

The undersigned does hereby unconditionally grant and contribute to Heart of Florida United Way, Inc., a Florida non-profit corporation, his or her voluntary authorization and consent, without payment or any compensation or royalty, to publish, print, show, display, reproduce, exhibit, transmit by any mechanic or electronic means, or otherwise publicly use or distribute, for any purpose, the following: (a) the undersigned's name, portrait, photograph, or other likeness and/or (b) any sound recordings, audiotapes, videotapes, or motion pictures depicting the undersigned's appearance in public or audiotapes, videotaped, or filmed while the undersigned was volunteering or acting in any capacity on behalf of HFUW. This authorization and consent shall bind the personal representative, heirs, successors and assigns of the undersigned, and shall insure to the benefit of the successors and assigns of HFUW, as well as any person or entity assisting HFUW voluntarily or for profit in the photographing, recording, taping or filming, or in any aspect of the reproduction or publishing contemplated herein.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\* A parent or legal guardian of the person must sign for a minor.